◇ New Hire ◇ Change

City of Rockville

LIFE INSURANCE ENROLLMENT AND BENEFICIARY CHANGE FORM

Name: _____Social Security Number: _____
Last First Middle Initial

Date of Birth: _____Sex: ◇ Male ◇ Female Date Employed: _____

Please check the appropriate box regarding supplemental life insurance coverage (additional coverage that is one times basic annual earnings at a monthly premium of $.25 per $1,000 of coverage):

◇ **Yes,** I accept the supplemental life insurance provided by the City's Group Insurance Plan and I authorize a payroll deduction for the premium that related to additional coverage in the amount of one times my basic annual earnings. I understand that I do not need evidence of insurability if I apply of this coverage with 30 days of my date of hire.
Late entrants must complete an Evidence of Insurability form. Coverage for late entrants is subject to the Insurance Company's approval.

◇ **No,** I have been offered the Supplemental Life Insurance and I decline to purchase this coverage at this time. I understand that if I wish to participate at a later date, I may be required to provide of insurability at my own expense and that coverage is subject to the Insurance Company's Approval.

Basic Annual Earnings: _____x 1.5 = $0.00 Amount of Base Coverage**

_____Amount of Supplemental Life Insurance***

$0.00 Total Coverage

*Basic Annual Earnings do not include bonus or overtime pay. Coverage amount subject to increase/decreases due to employee pay changes such as merit increments, etc.

**To calculate amount of base coverage: round 1.5 times your basic annual earnings to the next higher $1,000, but not to exceed a maximum of $250,000. Base coverage includes Accidental Death and Dismemberment coverage. See Group Insurance Plan booklet for more details.
***To calculate amount of supplemental coverage: round basic annual earnings to the next higher $1,000, not to exceed a maximum of $165,000.

BENEFICIARY DESIGNATION
I hereby designate the following beneficiary/beneficiaries; such designation will supersede any prior designation which I may have made under the City's group life insurance plan. Unless otherwise specified, if more that one beneficiary is designated, payments will be made in equal shares to those persons designated as beneficiaries who survive me.

Primary Beneficiaries:

Full Name	Date of Birth	Relationship to you	Social Security #	Address	Percent of Benefit
					0.00%
					0.00%
					0.00%

Contingent Beneficiaries: If no primary beneficiary lives longer than you, the benefit will be paid to any contingent beneficiary listed.

_____

_____

_____

Signature of Employee Date

WHITE COPY: Payroll YELLOW COPY: A/P PINK COPY: Personnel GOLD COPY: Employee

04/06